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MEDICAL SERVICE IN THE COMMUNICATIONS ZONE OF

THE EUROPEAN THEATER OF OPERATIONS

MISSION: To Make a Study of the Medical Service in the Communications Zone in the European Theater of Operations, to Report Upon the Effectiveness of New or Unusual Procedures Employed in the European Theater of Operations and to Make Recommendations for Changes to or Modifications of Existing Policies Pertaining to the Medical Service in a Communications Zone.

The General Board was established by General Orders 128, Headquarters European Theater of Operations, US Army, dated 17 June 1945, as amended by General Orders 162, dated 7 August 1945 and General Orders 312, dated 20 November 1945, Headquarters United States Forces, European Theater, to prepare a factual analysis of the strategy, tactics, and administration employed by the United States forces in the European Theater.

Prepared by  
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THE GENERAL BOARD  
UNITED STATES FORCES, EUROPEAN THEATER  
APO 402

MEDICAL SERVICE IN THE COMMUNICATIONS ZONE OF  
THE EUROPEAN THEATER OF OPERATIONS

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THE GENERAL BOARD  
UNITED STATES FORCES, EUROPEAN THEATER  
APO 408

MEDICAL SERVICE IN THE COMMUNICATIONS ZONE OF  
THE EUROPEAN THEATER OF OPERATIONS

CHAPTER 1

MEDICAL SERVICE IN THE COMMUNICATIONS ZONE PRIOR TO  
THE INVASION OF THE EUROPEAN CONTINENT

1. Prior to the invasion of the European Continent, the Chief Surgeon of the European Theater of Operations was responsible for providing medical service for all the United States troops in the United Kingdom, for staging and training medical department units and personnel and for making preparations to evacuate and hospitalize casualties received from the Continent of Europe prior to the establishment of the Communications Zone on the Continent. The War Department provided the Chief Surgeon of the European Theater of Operations with fixed hospital beds sufficient to hospitalize seven and seven tenths percent (7.7%) of the United States troops in the Theater.<sup>1</sup>

a. In order to provide medical service for the United States troops in the United Kingdom and to afford the maximum opportunity for training medical department units, the Chief Surgeon utilized representative units of the various types of hospitals available to him. These facilities were scattered throughout the British Isles so as to provide medical service for troop concentrations. The availability of buildings or construction facilities and of communication facilities were principal factors in determining the locations of medical installations.<sup>2</sup>

b. In preparing for the receipt of casualties anticipated in the invasion of France, hospitals were grouped around ports and airfields. These hospitals were grouped into hospital centers in order to expedite and facilitate the reception and evacuation of casualties. "Special treatment units" within the several hospital centers were utilized to provide highly skilled professional service for casualties suffering from chest wounds, neuropsychiatric conditions, hand injuries and injuries to the central and peripheral nervous systems. Specialized hospitals were also held in readiness for the treatment of chemical warfare casualties should the enemy resort to this type of warfare.<sup>3</sup>

2. The joint plans of the Chief Surgeon, European Theater of Operations, the Surgeon of the Advance Section, Communications Zone, and the Surgeon of the First United States Army have been reported upon in detail to the Surgeon General by the Surgeon of the Advance Section, Communications Zone, and need not be duplicated in this report.<sup>4</sup>

CHAPTER 2MEDICAL SERVICE IN THE COMMUNICATIONS ZONE FROM D-DAY UNTILTHE ESTABLISHMENT OF THE COMMUNICATIONS ZONEON THE EUROPEAN CONTINENT

3. The Advance Section of the Communications Zone was attached to the First United States Army prior to D-Day and the necessary elements of the Advance Section moved from the United Kingdom to France with the army headquarters. The Surgeon of the Advance Section, Communications Zone, and an advance party of the medical section arrived on the Continent on 16 June 1944, with the mission of evacuating the casualties occurring among the Allied Forces in the First United States Army's zone of action, the procurement, storage and distribution of medical supplies for United States troops ashore and the preparation of medical installations to be used by the Advance Section when the First United States Army established a rear boundary.<sup>4</sup>

a. Evacuation. Transportable casualties were evacuated to the United Kingdom over the beaches until air lift became available on D plus 6. Casualties which occurred in landing craft were retained in the craft and returned to ships standing off shore where they became the responsibility of naval medical units.<sup>5</sup>

b. Hospitalization. In the initial stages of the invasion, field and evacuation hospitals assigned to the Advance Section were operated in the First United States Army area to provide fixed hospital beds. As the tactical situation permitted, general and station hospitals were set up on the Continent to replace the field and evacuation hospitals for the purpose of providing fixed hospital beds.<sup>4</sup>

4. It had been anticipated that the First United States Army would establish a rear boundary by D plus 25. However, the delay in expanding the beachhead and particularly the delay in securing the port of Cherbourg resulted in considerable modification of the plans of the Communications Zone for furnishing medical service on the Continent. On D plus 23 (29 June 1944), the Surgeon of the First United States Army established a 10-day evacuation policy. However, most of the casualties which were ready for evacuation had to be retained in army hospitals because there was no advance section hospital in operation until the 12 Field Hospital opened at Cherbourg on D plus 34 (10 July 1944). The First United States Army did not actually establish a rear boundary until D plus 56 (1 August 1944).<sup>4</sup>

CHAPTER 3MEDICAL SERVICE IN THE COMMUNICATIONS ZONEON THE EUROPEAN CONTINENTSECTION 1

MEDICAL SERVICE IN THE ADVANCE SECTION OFTHE COMMUNICATIONS ZONE

5. On D plus 56 (1 August 1944), the Advance Section of the Communications Zone became operational in support of the 12 United States Army Group which was composed of the First United States Army and the Third United States Army. At this time 12 general hospitals, four field hospitals, one evacuation hospital (750-bed) and 16 other Advance Section medical units were on the Continent. The Advance Section of the Communications Zone was responsible for the port of Cherbourg (01523) until the Cherbourg Base Section (later changed to Normandy Base Section) became operational on 7 August 1944. The first rail evacuation on the Continent was from a rail evacuation holding unit at Lison (T5477) to the port of Cherbourg (01523) on 4 August 1944. Headquarters Forward Echelon, Communications Zone, followed the Advance Section to the Continent, assumed responsibility for rear areas and established base sections.<sup>4</sup>

6. Hospitalization in the Advance Section of the Communications Zone presented many difficult problems throughout the campaign. Although the original plan for medical service on the Continent did not call for many general hospitals on the Normandy Peninsula, the delay in breaking out of the beachhead, together with the bitter fighting in Normandy made it mandatory to provide a maximum number of hospital beds on the Continent. By D plus 30, one general hospital and three field hospitals had arrived on the Continent but the sites selected during the planning phase were still in the hands of the enemy and new sites had to be selected. Considerable delay in opening hospitals was experienced due to the lack of adequate hospital sites and as a result of the fact that hospital equipment did not arrive on schedule. Nine general hospitals were eventually established in Normandy, eight of them in tents, and one in buildings. During the rapid advance across Northern France, it was impossible for fixed hospitals to keep pace with the armies and casualties were evacuated by rail and air to Communications Zone hospitals in Paris (VS0544), Cherbourg (01523) and the United Kingdom. When the front became more stabilized along the German border, general hospitals were grouped in the Bar-le-Duc (VU1122) and Liege (VK4829) areas in support of the Third and First United States Armies, respectively. Buildings for hospital purposes were available in these areas but the repair and conversion of the buildings by the engineers proved to be a major undertaking and caused considerable delay and inconvenience.<sup>4</sup>

a. General hospitals were operated by the Advance Section of the Communications Zone both in the Normandy Peninsula and in the Bar-le-Duc (VU1122) and Liege (VK4829) areas but these hospitals performed very little general hospital type service. The opening of these general hospitals was delayed due to the difficulty of moving the hospital equipment and to the large amount of work required to prepare sites for this type of equipment. When the general hospitals were opened, it was found that the requirements for bed space necessitated the rapid evacuation of all casualties which could be transported. The experiences in the European Theater of Operations indicate that field hospitals and semi-mobile, 750-bed evacuation hospitals can be used much more effectively by the Advance Section of the Communications Zone and that general hospitals should be established only in the base, and possibly the intermediate, sections of the Communications Zone. Station hospitals should be replaced by field hospitals in the Advance Section.<sup>4</sup>

b. The Surgeon of the Advance Section, Communications Zone, controlled the evacuation of casualties from the armies through the medium of the medical regulating officer in the regulating station supporting the army. This system proved to be satisfactory but it was necessary to replace the company grade medical regulating officer in the regulating station with a field grade officer in order for him to function efficiently.<sup>4</sup>

c. As the armies advanced into Germany in the spring of 1945, the Advance Section of the Communications Zone was "stream-lined" by turning over its general hospitals to the Intermediate and Base Sections of the Communications Zone and the Advance Section supported the armies by using field hospitals and evacuation hospitals.<sup>4</sup>

d. Medical holding units were required by the Advance Section of the Communications Zone at transfer points along the main routes of evacuation. Field and evacuation hospitals and medical gas treatment battalions were utilized for this purpose. In many instances, general hospitals were little more than holding units. The Theater General Board has made recommendations in the report on "Organization and Equipment of Medical Units" for the organization of a medical holding unit which will meet the requirements of the Advance Section of a Communications Zone.<sup>4 & 6</sup>

## SECTION 2

### MEDICAL SERVICE IN THE INTERMEDIATE AND BASE SECTIONS OF

#### THE COMMUNICATIONS ZONE

7. The first base section to be organized on the Continent was the Cherbourg Base Section. This was later changed to the Normandy Base Section. As the Advance Section of the Communications Zone moved forward in support of the armies, its facilities were turned over to the Cherbourg Base Section. With the capture of Le Havre (VL4927), Rouen (VM2015), Paris (VS0544), and Antwerp (VJ7896) additional base sections were formed and medical supply and hospitalization facilities were established. As the Advance Section of the Communications Zone continued its advance across France into Germany, medical installations were turned over in place to the Oisc Intermediate Section of the Communications Zone. After the Chief Surgeon, Communications Zone, moved to the Continent, the hospitals in the United Kingdom functioned under the Surgeon, United Kingdom Base, and base section surgeons.<sup>4</sup>

a. General hospitals in the intermediate and base sections of the Communications Zone were able to function more nearly in the role for which they were designed than was the case in the Advance Section. Only the 1000-bed general hospital was shipped from the Zone of the Interior to the European Theater of Operations. When larger hospitals were required, they were organized in the European Theater of Operations by combining two or more 1000-bed hospitals. One neuropsychiatry general hospital was organized in the European Theater of Operations. General hospitals have operated efficiently in tents and this is practical when the weather permits. It is preferable however to have the basic hospital unit in buildings and to use tents for expansion beds and convalescent patients. General hospitals are capable of being moved when the situation demands it,

as has been shown by the 3 General Hospital which operated in Africa, Italy, France and Germany. This hospital established a record in its move from Africa to Caserta (RQ2070), Italy in that only 21 days elapsed from the time the last patient was discharged in North Africa until the first patients were received in Italy.<sup>3</sup> However every effort should be made to establish general hospitals in permanent locations and 750-bed evacuation hospitals should be used in lieu of general hospitals in temporary locations.<sup>4</sup>

(1) All hospitals in the Communications Zone in the European Theater of Operations were capable of carrying an overload for short periods of time. General hospitals were able to do this more easily than any of the others. However, the ability to carry an overload depended upon such factors as the physical set-up of the plant, the quality of the professional staff, the type of casualties being received and other variable factors. Generally these hospitals can operate without loss of efficiency with an overload of from 15 to 20 percent for short periods of time. However, individual hospitals should not be depended upon to carry an overload for any considerable time because the law of diminishing returns is applicable to human effort and the efficiency of the hospital deteriorates.<sup>4</sup>

b. The interchangeability of station and general hospitals. General hospitals are designed to serve general and special needs, rather than local and ordinary needs, the latter being the mission of station hospitals. Station hospitals normally receive patients only from the station, or locale, to which they pertain. They are neither organized nor equipped to assume the duties of a general hospital. When station hospital cases are admitted directly to general hospitals professional ability is usually not being utilized to the best advantage. There is no reason for reorganizing either station or general hospitals to make them interchangeable. Station and general hospitals have separate and distinct missions and there is a need for both types in a theater of operations. Except for short periods of time and emergency situations, these hospitals should be used to perform their respective missions. In the European Theater of Operations it is believed that the station hospitals were used for general hospitals and vice versa, on too many occasions. When this was done there was a loss in efficiency and a failure to use personnel and equipment to the best advantage of all concerned. 250, 500, 750-bed station hospitals were employed but the 500-bed was the hospital used to best advantage. Field hospitals, or elements of field hospitals, were used to good advantage when station hospitals of less than 500-bed capacities were required.<sup>9</sup>

c. "Special treatment" general hospitals. The only special treatment general hospital with a table of organization and equipment is the General Hospital (Neuropsychiatric), Communications Zone, which is organized under Table of Organization and Equipment C-550S, 4 February 1944. The neuropsychiatrists have consistently stated that, to achieve good results, neuropsychiatric cases should be seen and treated as near the front as possible. Since a general hospital is a fixed hospital and should not be in the more forward areas, the desirability of this unit is questionable and it is suggested that a more mobile unit might serve the needs better. Neuropsychiatric cases, upon arrival in a general hospital in a rear area, usually have lost their chance of return to full duty. They become Zone of Interior cases, or, at best, limited service personnel. It is believed that the general hospital type of neuropsychiatric work can satisfactorily be done by the neuropsychiatric section of a general hospital. It might be advisable to designate one general hospital in a hospital center as

the neuropsychiatric hospital and adjust the staff accordingly. This subject deserves considerable study from both professional and tactical standpoints.<sup>9</sup>

d. Convalescent hospitals, as such, were not employed in the Communications Zone but they could have been used to good advantage, especially in connection with hospital centers.<sup>9</sup>

e. Rotation of medical officers. The rotation of medical officers between professional and tactical assignments is desirable. Practically, it has not worked out well in the European Theater of Operations. Fixed hospital commanders and field medical unit commanders were not willing to release medical officers with excellent qualifications for medical officers with unknown qualifications. The mediocre ward surgeon generally makes only a mediocre battalion surgeon. Training of a civilian physician to be a good ward surgeon in a fixed hospital is no small task. There is never sufficient time to train them in both tactical and professional subjects. The professional training is lost or wasted when the officer is transferred from a hospital to a tactical unit. A large percentage of personnel in fixed hospitals are limited service individuals, and are unable to withstand the rigors of front line duty. These officers have, or should have, certain specialized skills which would be wasted in tactical units. To a limited extent, and in special cases, rotation of medical officers could certainly be practiced, but a general plan of rotation was not practicable in the European Theater of Operations during World War II. (See paragraph 17 of the Theater General Board's report on "Training Status of Medical Units and Medical Department Personnel upon their Arrival in the European Theater of Operations".)

## SECTION 2

### AFFILIATED HOSPITAL UNITS IN THE EUROPEAN THEATER OF OPERATIONS

8. The organization, mission and operation of hospitals staffed by affiliated units is the same as for any other hospital of the same type. In the European Theater of Operations there were 52 affiliated general hospitals and 15 affiliated evacuation hospitals, 750-bed. These affiliated units were organized early in the mobilization period and were among the first hospitals to arrive in the European Theater of Operations. The commissioned staffs of these units for the most part were made up of officers highly trained in the several specialties. The enlisted personnel however had not been trained with the civilian institution which the unit represents and were no different from enlisted men in non-affiliated units.

9. The principal advantage inherent in affiliated units is that they provide the Surgeon General a wealth of highly skilled physicians, surgeons and nurses who are accustomed to working together and who can operate an efficient hospital after a relatively short period of training during the early stages of their mobilization.

10. The affiliated units employed in the European Theater of Operations demonstrated several disadvantages. There was a disproportionate concentration of highly skilled professional personnel in these units that could have been utilized to better advantage had they been more equally distributed throughout the non-affiliated units. In some instances political and professional cliques were

brought into the unit from civilian life and caused some dissatisfaction within the units. The enlisted personnel in some affiliated units did not have the desired esprit de corps because they were not considered a part of the "family" since they did not belong to the civilian institution which had formed the affiliated unit. Officers who could have been utilized to better advantage in non-affiliated units were reluctant to be transferred because they desired to maintain the "old school ties".

#### SECTION 4

##### HOSPITAL CENTERS IN THE COMMUNICATIONS ZONE

11. A hospital center may be defined as a group of general, station and convalescent hospitals and such additional units as may be designated by proper authority, which operate under the administration of a single headquarters. In the European Theater of Operations there was considerable difference of opinion as to the exact mission of a hospital center.

12. There was a definite need for some such organization as a hospital center in the Communications Zone of the European Theater of Operations. This need was more in evidence in the intermediate and base sections than in the Advance Section of the Communications Zone. It was necessary to group general hospitals because one hospital usually could not receive and adequately care for the large number of casualties that would arrive on one hospital train or one group of planes. In the hospital centers certain hospitals were designated as special treatment hospitals and were staffed with specialists drawn from the other hospitals in the center. This greatly improved the professional service rendered the casualties. The hospital center commander was able to reduce materially the "dead beds" that would have been present in neuropsychiatric, female, contagious disease and officer wards had each of the general hospitals admitted these several types of casualties. The authority to transfer personnel within the center (hospital commanders excepted) relieved the Theater Surgeon's Office of this detail and resulted in more suitable assignments for personnel. Hospital centers employed the service of professional "coordinators" and these specialists performed a valuable service in maintaining high professional standards throughout the center. The hospital center was able to effect more efficient utilization of transportation, improve the utilities and maintain better special service activities than would have been possible had the general hospitals been operating separately. Unfortunately several of the hospital centers were commanded by officers junior to and with less experience than the officers commanding the hospitals in the center. This situation caused considerable dissatisfaction. In most instances hospital centers operated under the control of the commanding generals of communications zone sections. The surgeons of the communications zone sections in several instances were junior to both the hospital center commander and the general hospital commanders. The hospital center commander should be a brigadier general and should be carefully chosen with respect to his suitability and capability of fulfilling the assignment. He should be promoted to the authorized rank on assumption of command and should be given the prerogatives enjoyed by other general officers, such as the authority to issue awards and decorations. Hospital centers should operate under the theater command with the possible exception of supply and administration, which in many instances could be handled more efficiently by Communications Zone section commanders. 11 & 12

SECTION 5DENTAL SERVICE IN THE COMMUNICATIONS ZONE

13. There was sufficient dental personnel in units operating under approved tables of organization in the Communications Zone, European Theater of Operations. However, the dental personnel in these units were not able to provide for an adequate overall Communications Zone dental service, particularly at the larger headquarters and in cities such as London and Paris (VS0544). Fairly adequate dental service was eventually provided by organizing non-table of organization laboratories and clinics. There was a definite shortage of dental officers to provide this additional service and it was only accomplished at the expense of taking dental officers and technicians out of general hospitals, dispensaries and other medical units under Communications Zone control to staff the clinics and laboratories, thereby reducing the efficiency of the dental service of these units. A great amount of improvisation was required as a result of the failure to provide for adequate personnel and equipment in sufficient time to make the indicated service possible.<sup>13</sup>

14. As United States Forces increased in the United Kingdom, so did the size of the United States Headquarters in London. To provide out-patient medical and dental service to these forces two general dispensaries organized under column (GB), Table of Organization and Equipment 8-500 were established (1942-43). Later, one 150-bed station hospital was established in the London District. This, however, made a total of only seven dental officers for the entire London area. After considerable searching for personnel and equipment a non-table of organization dental clinic was established and staffed with 15 dental officers; six from two general dispensaries and nine from other organizations. The establishing of this clinic provided adequate dental service for the London area, although it did take dental personnel away from organizations when they were needed.<sup>14</sup>

15. Dental Service on the European Continent.

a. Detachment "E" of the First Auxiliary Surgical Group arrived in Normandy on D plus 51, but without its equipment. The detachment, nevertheless, set up a temporary clinic for communications zone troops in the vicinity of the Advance Section Medical Depot. Detachment "G", First Auxiliary Surgical Group, arrived on 2 August and set up at the 5 General Hospital, near Cherbourg (TA004); having all its equipment, the unit was able to provide the first adequate communications zone dental service on the Continent. The Central Dental Laboratory, a non-table of organization unit, was established in the Communications Zone at Valognes, France (02406) and later moved to Paris (VS0544). Three dental buses (one laboratory, one clinic, and one clinic and laboratory) were placed in operation to service communications zone troops. The mobile laboratory trucks of the First Auxiliary Surgical Group were also placed in operation, one each with the First and Third United States Armies and one to cover the replacement depots, where a large amount of work was accomplished.<sup>15</sup>

b. The London situation was repeated in Paris upon the arrival of United States troops in the area. Two general dispensaries (GB) (Table of Organization and Equipment 8-500) were established and, together with the hospitals in the zone, rendered what dental service they could, which was totally inadequate. Finally a 30-chair clinic was established in Paris (VS0544), and then all personnel were adequately covered for dental service. Personnel for the maintenance of this clinic were drawn from hospital centers, the general dispensaries

and units not functioning at the time.<sup>13</sup>

c. General and station hospitals in the vicinity of headquarters were not able to handle outside patients, due to the fact that it required the full time service of dental personnel authorized for the hospitals to care for their own personnel and patients.<sup>14</sup>

d. Another factor in large headquarters that enters into the picture is the large number of civilian personnel and liaison troops attached to these headquarters, without adequate provision being made for dental care.<sup>13</sup>

16. Dental prosthetic facilities in the Communications Zone, European Theater of Operations, were not sufficient to take care of the great amount of prosthetic work required. Smaller units without prosthetic facilities had to rely on dental laboratories some distance away from their locations by use of "impression chests" on loan from the Central Laboratory in Paris (VS0544), or London. Without these non-standard chests it would have been impossible to render any prosthetic service to units in the Communications Zone without loss of time in sending patients long distances for this service.<sup>13</sup>

17. Finally a non-table of organization Central Dental Laboratory was set up in London with three officers and 42 enlisted men and one was established at Valognes (02408), later moved to Paris (VS0544), with nine officers and 92 enlisted men, together with mobile non-standard busses to take care of the prosthetic requirements in the Communications Zone. The personnel were drawn from hospitals and other medical units in the Communications Zone.<sup>13</sup>

18. The dental service in Communications Zone general hospitals was adequate and efficient. The table of organization provided for an adequate number of professionally qualified dental officers, but there were not enough technicians. For each 1000, 1500, and 2000-bed hospital, one additional laboratory technician (067), one additional technician, x-ray, dental (264), and one additional dental technician (855) were needed. There was no shortage of supplies and equipment. The organizational and supply problems of all medical units is the subject of a separate report.<sup>14</sup>

19. Adequate dental service in station hospitals was provided in the Communications Zone hospitals. There was no shortage of officer personnel, but an additional enlisted dental technician (855) for the 500 and 750-bed hospitals would have been desirable.<sup>14</sup>

20. General dispensaries and dental clinics. Two (GB) general dispensaries (Table of Organization and Equipment L-500) and one dental clinic were established in London and Paris (VS0544), alike. The dental personnel in the dispensaries were placed in the clinics, however, so that all the dental service was provided at the clinics. These clinics were not table of organization units and the personnel were secured from the general dispensaries, general hospitals and medical units not in operation. The equipment consisted of what could be made available from depot stocks, including captured equipment. The dental service provided for in the (GB) general dispensaries was never adequate and, in cities where they were set up, the dental service had to be augmented by the establishment of separate large dental clinics. (GB) dispensaries render out-patient medical and dental treatment to an area, or installation, with a troop population of from 5000 to 10,000. This does not include civilian employees, United Service Organization and American Red Cross personnel, liaison officers and casualties. This total population receiving

dental service puts an additional burden on the dispensaries so that other provisions have to be made, in most instances, for rendering the necessary dental treatment. There is need for dental service at these dispensaries, whether or not dental clinics are established and two additional dental officers, one more dental laboratory technician (067) and three more dental technicians (855), plus the additional equipment, would have made this possible. As a general rule, it is believed that whenever and wherever a general dispensary is established there will be more dental work than three dental officers can take care of and that the dental section personnel should be increased.<sup>13</sup>

21. Evacuation hospitals, 750-bed and field hospitals. Dental personnel, supplies and equipment were adequate. There were no major problems pertaining to the dental service in these hospitals. The evacuation hospitals did render considerable out-patient dental treatment which did not interfere with the primary mission of the section.<sup>13</sup>

22. Personnel of units whose table of organization did not authorize dental personnel received only mediocre dental service, as a rule. These units depended on dispensaries, hospitals, clinics and other units in the area for their dental service and in most instances only the emergency cases received attention. These units did not compare favorably from a dental standpoint with units that did have dental personnel. However, such units located near the large dental clinics did receive adequate dental care.<sup>13</sup>

23. If personnel and equipment for one dental operating detachment per 25,000 troops (as organized under column (LH), Table of Organization and Equipment 8-500), had been available, they would have been adequate for the dental needs of units without organic dental service. However, no trucks for the detachments were available until April 1944, and then only 50 percent of those authorized arrived in the European Theater of Operations. Personnel to man the equipment had to be supplied from other units.<sup>13</sup>

24. The established policy of the Ground Force Reinforcement Command was that no men were to be shipped out of a reinforcement depot if they "had insufficient teeth to masticate army field rations". Men in this category were given first priority for dental work and pending the changing of the classification, were held as "unavailable for assignment". Men who required routine dentistry were not held as unavailable for assignment, but were given as much dental care as possible during the time they were in the depots. The operation of the reinforcement units in the Ground Force Reinforcement Command brought out two weaknesses as regards the dental setup. There was a definite need for a depot dental surgeon to coordinate and supervise the volume of dental work in the reinforcement depot. This officer should be a member of the depot medical section and should be in the grade of major. There is also a very definite need in each reinforcement depot for dental prosthetic laboratory facilities.<sup>13</sup>

25. Dental supplies in the Communications Zone were not adequate at all times, particularly during the early phases of the operations. Both in the United Kingdom and on the Continent, there were shortages of teeth, stone, alloy, mercury, and the impression materials. It was necessary to substitute on occasion and to use captured materials at other times. Base chairs, electric engines and laboratory equipment were utilized to a great extent.<sup>13</sup>

26. There were, at times, long lags between date of requisitions and date of receipt of supplies. Many requisitions were never filled. Many of the complaints pertaining to dental supplies were due to

inexperience, failure to look ahead and failure to requisition the needed supplies in time to allow the depots to secure adequate stocks. The condition improved later, however, and dental supplies were obtained without any particular difficulty.<sup>13</sup>

## CHAPTER 4

### CONCLUSIONS AND RECOMMENDATIONS

#### SECTION 1

#### CONCLUSIONS

27. The following conclusions are drawn from this study:

a. General hospitals function more efficiently when grouped near ports, airfields or railroad terminals but the availability of hospital plant facilities determines the extent to which this is possible.

b. Considerable time is required for the movement of general hospitals and for the preparation of the sites selected for their plants.

c. The policy of shipping only 1000-bed general hospitals to the European Theater of Operations was sound.

d. "Special treatment" general hospitals were not absolutely necessary in the European Theater of Operations. These functions could have been performed by designating certain general hospitals in hospital centers for the treatment of special conditions and staffing them accordingly from the personnel available to the hospital center commander.

e. It is not economical of professional personnel and medical equipment to utilize general hospitals in forward areas where they act only as holding units or evacuation hospitals.

f. Field and evacuation hospitals are more suitable for use by the advance section of a communication zone in the initial stages of an amphibious operation than are station and general hospitals.

g. Medical holding units are required at transfer points along main routes of evacuation. (The Theater General Board has made recommendations for the organization of such a unit in the report on "Organization and Equipment of Medical Units".)

h. Station and general hospitals are each organized to perform a special mission and it is not economical or conducive to the best type of professional service to use these hospitals interchangeably. Field hospitals or elements of field hospitals may be used to good advantage to replace the smaller station hospitals.

i. Convalescent hospitals were not employed by the Communication Zone in the European Theater of Operations but the need for them existed

j. Hospitals are able to operate efficiently with an overload of 15 to 20 percent for short periods of time. However, the law

of diminishing returns is applicable to human effort.

k. Hospitals in the communications zone function more efficiently when they operate under the control of hospital centers. Appropriate recommendations for the organization of a hospital center have been made in the Theater General Board's report on "Organization and Equipment of Medical Units".

l. Affiliated hospital units performed a very valuable service in the European Theater of Operations but generally tended to concentrate a disproportionate amount of professional skill in these units.

m. The rotation of medical officers between the armies and the communications zone was found to be impractical in the European Theater of Operations. Paragraph 17 of the Theater General Board's report on "Training Status of Medical Units and Medical Department Personnel Upon Their Arrival in the European Theater of Operations" outlines a system which will make such rotation practical in future operations.

n. The medical regulating officer in the regulating station supporting an army can effectively control the evacuation of casualties and the movement of medical supplies provided he is of field grade.

o. The maintenance of the high standards of dental service to which United States military personnel are accustomed requires an increase in the operative and prosthetic facilities over that which was included in the plans for the dental service in the European Theater of Operations.

p. The volume of dental service needed in reinforcement depots was greater than had been anticipated and facilities were inadequate to meet the need.

q. The non-standard "impression chests" which were developed in the European Theater of Operations proved quite satisfactory.

## SECTION 2

### RECOMMENDATIONS

2E. It is recommended that:

a. The 750-bed evacuation hospital be made semi-mobile and included in the troop lists of advance sections of the communications zone in future operations to provide close support to the armies in the early phases of an amphibious operation and in fast moving situations.

b. The tables of organization for the 1500-bed and 2000-bed general hospitals be retained as a basis for organizing such hospitals in a theater of operations only.

c. The organization of special treatment general hospitals be abolished in a theater of operations.

d. Convalescent hospitals be considered an integral part of hospital centers in plans for future operations.

e. A plan be developed to distribute the highly skilled medical professional talent more equitably than has been done in the affiliated hospital units.

f. The medical regulating officer in the regulating station be authorized in field grade (preferably a lieutenant colonel, Medical Corps) rather than the company grade officer authorized by current tables of organization.

g. A dental prosthetic detachment (mobile), column (BH), Table of Organization and Equipment 8-500 be incorporated into the table of organization for the medical section of reinforcement depots and that the senior dental officer be given field grade rank.

h. The "Impression chests" developed in the European Theater of Operations be adopted as standard equipment.

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